Cascade Surgical Partners

Date:__________________________
Account Number:_______________

PATIENT INFORMATION

First Name_____________________MI____Last Name_________________
Address____________________________Mailing_____________________
City_________________________________State_____________Zip_______
Telephone_____________________Birthdate_____________Sex_________
SS#_____________________________Spouse's Name_________________
Employer____________________________Work Phone_______________
Do you have a cell phone we may call?______________________________
Emergency Contact (please list someone who does not live with you)
Name________________________Phone__________Relationship_______
Name of Doctor who referred_______________Family Doctor___________

GUARANTOR INFORMATION
(Please fill this information out if patient is a minor)

First Name_______________Last Name_____________Relationship______
Address (If Different from above)___________________________________
City_____________________________State__________Zip_____________
Telephone________________________Cell Phone_____________________
SS#_________________________Birthdate_________________Sex_______
Employer__________________________Work Phone__________________

Please Note: You are responsible for the payment of this account. We will, however, routinely bill your insurance for you if you provide you with that information. If you have any questions regarding your bill, please ask to speak with someone in our Billing Department.

I hereby authorize Dr. Bernfeld/Dr. Conroy/Dr. Kisala/Dr. Young to release any information required by my insurance company in order for payment of my account. I hereby assign to the doctor all the money to which I am entitled for medical and/or surgical expenses for my services received.

Patient or Guardian
Signature____